PRINTED: 08/07/2014
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN9506	A. BUILDING: _____ B. WING _____	08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 001	1200-8-6 Initial Comments During the annual Licensure survey and investigation of complaints #33919, #33442, #32905, #32404, and #32456, conducted on July 28 - August 1, 2014, at Mt. Juliet Health Care Center, no deficiencies were were cited under 1200-8-6, Standards for Nursing Homes.	N 001		

ivision of Health Care Facilities
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

TATE FORM 6899 49H311 If continuation sheet 1 of 1